Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ECTOR COUNTY HOSPITAL DISTRICT

Respondent Name
INSURANCE CO OF THE STATE OF PA

MFDR Tracking Number
M4-11-2674

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 6, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Outpatient Hospital Rule 134.03, HCPS's are payable at 200% of the correct fee schedule allowable."

Amount in Dispute: $132.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "the carrier's position is that the MCPS claim shows the correct PPO discount at 10% per the contract as what the provider expects."

Response Submitted by: Chartis

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 14, 2010	Outpatient Magnetic Resonance Imaging Services	$132.53	$132.53

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §133.4 requires written notification to health care providers regarding contractual agreements for informal and voluntary networks.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 45 – Charges exceed your contracted/legislated fee arrangement.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - 1 – Recommendation of payment has been based on this procedure code, 72141, which best describes services rendered. (Z652)
   - 2 – This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business. (P303)
   - 3 – The charge for this procedure exceeds the fee schedule allowance. (Z710)

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The insurance carrier reduced payment for the disputed service with claim adjustment codes 45 – "Charges exceed your contracted/legislated fee arrangement."; and 2 – "This contracted provider or hospital has agreed to reduce this charge below fee schedule or usual and customary charges for your business. (P303)." The respondent's position statement asserts that "the MCPS claim shows the correct PPO discount at 10% per the contract as what the provider expects." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual fee arrangement between the parties to this dispute. The respondent did not submit any documentation to support the insurance carrier's reduction reasons. The submitted documentation does not include a complete copy of the alleged contract(s) that the respondent seeks to apply. No documentation was found to support that the insurance carrier is a party to the alleged contract. No documentation was found to support that the insurance carrier had been granted access to the health care provider's contracted fee arrangement with the alleged network during the period that the disputed services were rendered. No documentation was found to support that the health care provider had been given notice, in the time and manner required by 28 Texas Administrative Code §133.4, that the insurance carrier had been granted access to the health care provider's contracted fee arrangement at the time the disputed services were rendered. The Division concludes that, pursuant to §133.4(g), the insurance carrier is not entitled to pay the health care provider at a contracted fee. Consequently, per §133.4(h), the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. This dispute relates to magnetic resonance imaging services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules, which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code 99144 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
   - Procedure code 72141 has a status indicator of Q3, which denotes conditionally packaged codes paid through a composite APC if OPPS criteria are met. This service meets the criteria for composite payment. This service is assigned to composite APC 8007. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. The payment for composite services is calculated below.
   - Procedure code 72148 has a status indicator of Q3, which denotes conditionally packaged codes paid through a composite APC if OPPS criteria are met. This service meets the criteria for composite payment. This service is assigned to composite APC 8007. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. The payment for composite services is calculated below.

- Procedure codes 72141 and 72148 have status indicator Q3, which denotes packaged codes paid through a composite APC. A service that is assigned to a composite APC is a major component of a single episode of care. The hospital receives one payment through a composite APC for multiple major separately identifiable services. Payment for any combination of designated procedures performed on the same date is packaged into a single payment. These services are assigned to composite APC 8007, for magnetic resonance imaging (MRI) services without contrast. If a claim includes a composite payment that pays for more than one otherwise separately paid service, the charges for all services included in the composite are summed up to one line. To determine outlier payments, a single cost for the composite APC is estimated from the summarized charges.

  Per OPPS Addendum A, APC 8007 has a payment rate of $712.29. This amount is geographically adjusted by dividing the payment into 2 portions representing the labor-related and non-labor percentages of the payment. The labor-related portion is 60% of the payment amount, or $427.37, and the non-labor portion is the remaining 40%, or $284.92. The labor-related portion is multiplied by the annual wage index for the facility's location of 0.9836, which yields an adjusted labor-related amount of $420.36. This amount is added back to the 40% non-labor portion. The sum is the geographically adjusted APC rate. The sum of the labor-related and non-labor amounts is $705.28, which is the OPPS payment for this line item.

  The cost of these services does not exceed the annual fixed-dollar threshold of $2,175. Therefore these services do not qualify for an outlier payment.

  The total Medicare facility specific reimbursement amount is $705.28. This amount multiplied by 200% yields a MAR of $1,410.56.

4. The total allowable reimbursement for the services in dispute is $1,410.56. The amount previously paid by the insurance carrier is $1,242.90. The requestor is seeking additional reimbursement in the amount of $132.53. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $132.53.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $132.53 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	March 13, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.